

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER The Villas at New Brighton		STREET ADDRESS, CITY, STATE, ZIP CODE 825 First Avenue Northwest New Brighton, MN 55112	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a self-administration of medications assessment was completed, and orders obtained, for all medications kept at bedside for 1 of 1 resident (R4) observed with medications at their bedside. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition with diagnoses which included femur fracture, severe obesity, and asthma. R4's self-administration of medication evaluation dated 2/3/25, indicated ok to leave medication after nurse set up. In the section, the resident was able to demonstrate to the satisfaction of the nurse manager or designee, the assessment boxes indicated for the ability to produce all currently used medication containers and that these reflect the current physician-prescribed medications and all medications are stored properly (if stored in resident's room) was not checked. R4's current provider order list dated 9/10/25, lacked orders for Tums (calcium carbonate [used to treat heartburn]), Tussin DM (dextromethorphan and guaifenesin [used to treat cough]), and a multi-vitamin. During observation on 9/9/2025 at 11:31 a.m., the following medication containers were observed on R4's bedside table: tums, Tussin DM, multi vitamin and anti-diarrheal medication. During an interview on 9/9/2025 at 11:57 a.m., licensed practical nurse (LPN)-A stated R4 could self-administer medication after a nurse set up. The medications were kept in the nurse's cart. LPN-A confirmed R4 had tums, Tussin DM, multi vitamin and anti-diarrheal medication on her bedside table and R4 did not have a provider order for tums, Tussin DM, or a multi vitamin. LPN-A stated all medication containers should have been kept in the nurse's cart. If a nurse observed a medication container in a resident room, they should ask the resident if the medication can be placed in the nurse's cart and the provider should be notified. During an interview on 9/10/2025 at 11:33 a.m., R4 stated she had ordered the tums, Tussin DM, multi vitamin and anti-diarrheal medication for herself online a while ago and no staff member had asked her about them. R4 stated she liked to take the tums whenever her stomach was upset and could not remember how often she was taking it. During an interview on 9/10/2025 at 1:20 p.m., the director of nursing stated a nurse was expected to complete an assessment on a resident who wanted to self-administer medications. In addition, a provider order is needed for all medications. If a resident was deemed safe to self-administer medication and keep the medication at bedside, the medication should be stored in a safe and secure place where other residents would not have access to them. DON stated a bedside table was not a safe and secure location. DON confirmed R4 could self-administer medication after nurse set up however, was not being done correctly. Medication bottles should not be left on the bedside table. When a nurse observed a medication container in a resident's room, they should place the medication in the cart and contact the provider. Review of the facility policy titled The Self-administration of Medications policy dated 2/2024, indicated self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 245164	If continuation sheet Page 1 of 4

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report to the State Agency (SA) a serious bodily injury that resulted from the improper use of a full mechanical lift for 1 of 4 residents (R1) reviewed for falls. Findings include:The Minnesota Adult Abuse Reporting Center did not contain any facility reported incidents related to R1's reported fall from full mechanical lift with subsequent femur fracture on 8/29/25.R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition with diagnoses which included colon cancer, fracture of left humerus and hemiplegia.Nursing progress notes identified on 8/29/25 at 9:45 p.m., 2 staff members were transferring R1 from his bed to a shower chair with a full mechanical lift. During the transfer, one loop of the sling handle came off of the lift hook, R1's right leg slid out of the sling and R1 landed on the floor in a sitting position then ended on his back. The administrator, director of nursing and on-call provider were notified. R1 was transported to the hospital for evaluation and had subsequent surgery for a left femur fracture. During an interview on 9/9/2025 at 3:23 p.m., the administrator stated R1 falling from the lift was determined to not be the result of abuse, neglect, exploitation, or misappropriation so it was not reportable. It was an accident.During an interview on 9/10/2025 at 12:14 p.m. after reviewing incident video, the director of nursing stated the nursing assistants were not following manufacturer's instructions when they attached the sling to the lift prior to transferring R1. R1 fell from the sling because the sling came off the lift hook. Review of facility policy titled The abuse prohibition/Vulnerable Adult Policy dated 4/2025, instructed incidents to be reported including all serious injuries that were determined to be a result of abuse, neglect, exploitation, or misappropriation, even those considered accidental. Examples of serious injury include but were not limited to falls with major injury (including fractures, closed head injury, internal bleeding and death), burns, medication errors with adverse effects or potential for adverse effects, or other resident incidents.		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure safe transfers with a full body mechanical lift. This resulted in an immediate jeopardy (IJ) for 1 of 4 residents (R1) who sustained a left femur fracture due to a fall from a lift. The immediate jeopardy (IJ) began on 8/29/25, when R1 fell out of a full mechanical lift sling that was not attached to the lift according to manufacturer instructions resulting in a fall with fracture for R1. The administrator and director of nursing (DON) were notified of the IJ on 9/10/25 at 1:49 p.m. The IJ was removed on 9/2/25, prior to the start of the survey, when the facility implemented immediate corrective action to prevent recurrence, therefore, the IJ was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated intact cognition with diagnoses which included colon cancer, fracture of left humerus and hemiplegia. R1's care plan dated 6/10/25, indicated R1 required assistance of total/Hoyer mechanical lift (purple/medium sling or large green sling can be used). An orthopedic trauma provider consultation note from the hospital dated 8/30/25, indicated the history of the present illness included a fall from a Hoyer lift. R1 was found to have an acute left femur fracture that required surgical intervention. A hospitalist progress note dated 8/31/25, included under hospital summary: patient (R1) was at a facility and they were using the Hoyer lift to move [R1] when the lift failed and [R1] fell about 3 feet to the ground. Following the fall, [R1] had significant left hip pain and was brought to the emergency department (ED). In the ED, workup revealed a left subtrochanteric (femur) fracture. A nursing note dated 8/30/25 at 12:03 a.m., indicated at 9:45 p.m., 2 staff members were transferring R1 from his bed to a shower chair with a Hoyer lift. During the transfer, one loop of the sling handle came off the Hoyer hook, R1's right leg slid out of the sling and R1 landed on the floor in a sitting position and ended up on his back. A nursing note dated 8/30/25 at 3:57 p.m., indicated R1 had surgery following a left femur fracture. During an interview on 9/9/2025 at 2:47 p.m., family member (FM) stated she watched the video of when R1 fell out of the sling. She stated it was a horrible thing to watch. The strap on the lower left side did not appear to be attached correctly to the lift and came off during the transfer. FM confirmed R1 had a left femur fracture which required surgery with rod placement. During an interview on 9/9/25 at 4:12 p.m., nursing assistant (NA)-A stated she knew the correct way to hook the sling to the lift and identified the strap needed to be placed into the hook. NA-A stated she was assisting on 8/29/25, to transfer R1 from his bed to a shower chair using a full mechanical lift. She did not notice anything wrong with the straps when she attached them to the lift. During the transfer, one of the straps on the sling somehow came off the hook and R1 fell to the floor. NA-A stated she knew the correct way to hook the sling to the lift. The strap needed to be placed into the hook. During an interview on 9/9/25 at 4:34 p.m., licensed practical nurse (LPN)-B stated she was notified by NA-A about R1 falling from the sling onto the floor. When LPN-A entered the room, R1 was on the floor and saying Ow Ow and don't touch me. LPN-A called 911 to transfer R1 to the hospital for evaluation. During an interview on 9/10/25 at 9:09 a.m., a customer service representative from the manufacturer of the full mechanical lift stated a sling could detach from a lift hook if the person in the sling was over the weight limit, the sling was worn out or if the sling was improperly attached. The weight limit for all slings is 600 pounds. A sling used less than one year should still be in good condition if used and cleaned according to manufactures instructions. During an interview on 9/10/25, following incident video review, the DON confirmed the lower right strap had not been connected to the lift correctly and as a result it came off the hook and R1 fell to the floor. DON stated NA-A and NA-B were not following manufacturer's instructions for proper sling attachment during the transfer. DON confirmed the lower right sling loop was placed at the top of the hook instead of the lower part of the hook. Two attempts were made to contact NA-B with no return phone call. The manufacturer full body sling instruction manual undated, identified the sling was correctly attached to the lift when the loops of the sling were placed at the bottom of the hooks. The manual warnings include: if the sling is not properly applied, personal injury and damage to the sling could occur. The facility mechanical lift competency instructs: Attach the sling to the lift assuring that the loops are secured to the hooks. Review of facility policy titled The facility safe resident handling program policy undated, instructed when residents received care require assistance from facility to move, assistance was provided in a manner that was safe to both the resident and employee. The facility implemented the following actions prior to the survey which were verified through interview and document review and therefore the IJ was issued at past non-compliance: Staff involved in the incident were immediately suspended pending investigation. The lift and sling were out of</p>		